DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/24/2011 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		085026	B. WING _	• • • • • • • • • • • • • • • • • • •	05/1	1/2011
NAME OF PROVIDER OR SUPPLIER STONEGATES			4	REET ADDRESS, CITY, STATE, ZIP CODE 031 KENNETT PIKE GREENVILLE, DE 19807		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS .	F 000			
F 279 SS=D	at this facility from 2011. The deficient are based on obset residents' clinical re- facility documentations the first day survey Stage 2 san residents. 483.20(d), 483.20(l)		F 279			
		the results of the assessment and revise the resident's n of care.				
•	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable etables to meet a resident's nd mental and psychosocial etified in the comprehensive				
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under { due to the resident	t describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment.				
	by: Based on observa	NT is not met as evidenced tion, record review and		TITLE		(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

6/2/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE SI COMPLE	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 4031 KENNETT PIKE GREENVILLE, DE 19807		72011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279	interview, it was del to develop a care pl out of 22 stage 2 sa failed to develop ca goals and interventi	ge 1 termined that the facility failed lan for 3 (R29, R32 and R51) ampled residents. The facility re plans with measurable ons for psychotropic drug use 51. Findings include:	F 2	The three residents at have been reviewed a plans put in place as a	nd care	5/10/2011
	revealed, "The residual plan is developed w	Plan policy, last revised 10/10 dent's comprehensive care within seven (7) days of the esident's comprehensive	·	All residents receiving medications will be re MDS Coordinator for care planning.	viewed by DON/	
	and agitation. R32's medications Rispers 12/28/10, Clonazep 3/8/11 and Ativan (a 1/6/11. Review of the annual assessment, dated received both anti-permedications in the permedications in the permedication of the permed	es of dementia with delusions physician ordered the dal (anti-psychotic) on am (anti-anxiety/agitation) on anti-anxiety) as needed on al Minimum Data Set (MDS) 3/29/11, revealed that R32 sychotic and anti-anxiety past 7 days. The Care Area Summary, dated 3/31/11, for psychotropic drug use or care planning. However, no loped for psychotropic drug		Any resident who rece for a psychotropic me reviewed by the MDS Coordinator/designee of an appropriate care	dication will be for implementation plan.	
	confirmed by both E Coordinator). 2. R51 was admitted	in interview, findings were (2 (DON) and E3 (LPN, MDS) do to the facility on 11/27/10		report will be reviewed Coordinator to determ receiving psychotropic have an appropriate ca the use of psychotropi	d by the DON/MI ine that all resider medications will are plan related to	nts

with diagnoses that included dementia and chronic insomnia. Admission orders, dated

11/27/10 included an order for Temazepam

6/30/2011

PRINTED: 05/24/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 085026 05/11/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4031 KENNETT PIKE STONEGATES** GREENVILLE, DE 19807 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY** F 279 Continued From page 2 F 279 (hypnotic) 15 mg by mouth at bedtime for chronic insomnia. The 12/8/10 admission Minimum Data Set (MDS) assessment stated R51 was having trouble falling asleep or staying asleep and had received a hypnotic during the past seven (7) days. Although the Care Area Assessment (CAA) Summary triggered for Psychotropic Drug Use, it was not checked off to be care planned and there was no documentation stating the rationale as to why care planning was not done. Review of the clinical record revealed that although the facility was monitoring R51 for potential side effects from the use of the Temazepam, they failed to develop a care plan for it's use. During an interview with E2 (Director of Nursing) and E3 (MDS Coordinator) on 5/10/11, they both stated that although they monitor for side effects of the medication, it was not a problematic area for the resident thus they did not care plan for it. 3. R29 had diagnoses of dementia with delusions and agitation. R29's physician ordered Clonazepam, an anti-anxiety/agitation medication beginning 2/18/11.

days.

Review of the quarterly Minimum Data Set (MDS) assessment, dated 3/16/11, revealed that R29 was coded for an anxiety disorder and had received anti-anxiety medication in the past 7

Review of R29's 5/11 MAR (Medication Administration Record) and 5/11 Behavior

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	·	085026	B. WIN	1G _	·	05/1	1/2011
NAME OF PROVIDER OR SUPPLIER STONEGATES				4	REET ADDRESS, CITY, STATE, ZIP CODE 1031 KENNETT PIKE GREENVILLE, DE 19807		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 279	Monitoring Sheet re receive this medica for side effects. Ho	ge 3 evealed that R29 continued to tion and was being monitored ewever, no care plan was hotropic drug use for R29.	F:	279			
	(LPN, MDS Coordin care plans had bee noted that R29 had (brand name for Clo	on 5/10/11 at 3:05 PM, E3 nator) stated that when R29's n reviewed on 3/22/11, it was been "Started on Klonopin onazepam)", that she should 'to monitor for side effects for					
F 371 SS=D	interview on 5/10/1 a care plan with me interventions to add and to prevent adve R29's medication, (483.35(i) FOOD PR	irmed by E3 during an 1. The facility failed to develop easurable goals and fress the use of a medication erse effects or side effects for Clonazepam (Klonopin). ROCURE, //SERVE - SANITARY	F;	371			
	considered satisfact authorities; and	om sources approved or tory by Federal, State or local distribute and serve food ditions			The facility has now purchase pasteurized eggs and has deve a new procedure to allow for the serving of pasteurized eggs or soft poached eggs. The Director of Food Services/Executive Chef and Dietician will monitor adhere the procedure on an ongoing	eloped over-easy the ence to	
	by: Based on observat department, staff in	NT is not met as evidenced tions made in the dietary terviews and facility ew, it was determined that the					5/11/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
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F.371	sanitary conditions undercooked unpass resident (R39). This borne illness. Finding Observations in the AM revealed unpassinside the reach-in and E8 (both dietar they served the unpone resident (R39) poached. E7 stated this way when they resident. Review of nurses in requested soft cook associated with the was explained to the dated 5/4/11 indicateggs cooked over-earth interview with E4 (F	pare and serve food under when they served steurized shelled eggs to one is has the potential for a food ings include: kitchen on 5/5/11 at 10:15 steurized shell eggs stored refrigerator. Interview with E7 y staff) on 5/5/11 revealed that pasteurized shelled eggs to cooked over-easy and soft dithat they served the eggs had a doctor's order for the otes revealed that R39 ked eggs on 6/19/09. The risks use of the eggs undercooked in resident. A doctor's order ted "it was ok for R39 to have easy or poached soft".	F.	371			
F 441 SS=E	finding. He stated the over-easy and soft residents' request. purchased pasteurinew procedure to a pasteurized over-eaggs. 483.65 INFECTION SPREAD, LINENS The facility must es	Chef) on 5/9/11 confirmed this nat they served eggs cooked poached to accommodate. The facility has now zed eggs, and developed a llow serving residents asy eggs or soft poached. I CONTROL, PREVENT stablish and maintain an regram designed to provide a	F	441			
		comfortable environment and					

PRINTED: 05/24/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 085026 05/11/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4031 KENNETT PIKE STONEGATES** GREENVILLE, DE 19807 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 441 Continued From page 5 F 441 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -(1) Investigates, controls, and prevents infections in the facility: (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and

infection.

by:

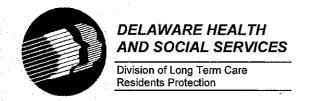
transport linens so as to prevent the spread of

This REQUIREMENT is not met as evidenced

Based on observations during the tour of the laundry room and staff interview, it was

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NAME OF PROVIDER OR SUPPLIER STONEGATES (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X5) COMPLETION (X6) PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X5) COMPLETION

·		085026	B. WING		05/11/2011
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F 441	spread of infection as reflected by the sharing a common failed to provide a reformation to the washing of streviewed. The proof Guidelines" under to "The laundry room and maintained under the laundry. The expectation of the with E5 (Director of 11:32 AM revealed directly connected the laundry. The expectation of the dryer side. To observed under nemissing a vent systic dirty air to the outsing potential for introdusoiled linen washed dryer area.	e facility failed to prevent the during the handling of linens clean and dirty linen rooms exhaust vent. The facility room under negative pressure soiled linen. Findings include: on Control Policy was redure entitled "Laundry Haundry Facility" stated that area should be well ventilated der negative pressure". It all laundry room washer area of Housekeeping) on 5/10/11 at an exhaust vent grill that was on the wall to the clean area of thaust system was observed the washer area was not gative pressure and was tem that directly exhausted the de of the facility. This had the area to the clean linen in the Plant Services Director) on this finding.	F 44	Ductwork will be installed and re-routed in the laundry area to assure the area is well ventilated and maintained under negative pressure. The soiled linen area be maintained under negative pressure and tied into the exist ventilation system which is divented to the outside. The Director of Plant will be responsible for monitoring completion of the work and maintaining compliance in the future.	o ced e a will ting rectly



Provider's Signature Kim m. Can

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STATE SURVEY REPORT

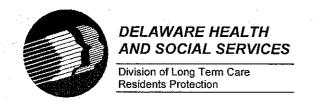
Page 1 of 3

NAME OF FACILITY: Stonegates

DATE SURVEY COMPLETED: May 11, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility from May 5, 2011 through May 11, 2011. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 38. The survey Stage 2 sample totaled twenty two (22) residents.	
3201	Regulations for Skilled and Intermediate Care Facilities	
3201.1.0	Scope	
3201.1.2	Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.	
	This requirement was not met as evidenced by:	
	Cross refer to CMS 2567-L survey report date completed 5/11/11, F279 and F441.	
3201.7.5	Kitchen and Food Storage Areas.	
	Facilities shall comply with the	

Il 611 Date Manual Date 112 ...



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STATE SURVEY REPORT

Page 2 of 3

NAME OF FACILITY: Stonegates

DATE SURVEY COMPLETED: May 11, 2011

SECTION

STATEMENT OF DEFICIENCIES Specific Deficiencies

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED

Delaware Food Code.

3-302.13 Pasteurized Eggs, Substitute for Raw Eggs for Certain Recipes.

Pasteurized eggs or egg products shall be substituted for raw eggs in the preparation of foods such as Caesar salad, hollandaise or Béarnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages that are not:

(A) Cooked as specified under Subparagraphs 3-401.11(A)(1) or (2); P or (B) Included in ¶ 3-401.11(D). P

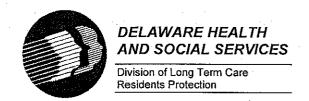
3-401.11 Raw Animal Foods. (Cooking)

- (A) Except as specified under ¶ (B) and in ¶¶ (C) and (D) of this section, raw animal foods such as eggs and foods containing these raw animal foods, shall be cooked to heat all parts of the food to a temperature and for a time that complies with one of the following methods based on the food that is being cooked:
- (1) 63oC (145oF) or above for 15 seconds for: P
- (a) Raw eggs that are broken and prepared in response to a consumer's order and for immediate service, P and
- (D) A raw animal food such as raw egg, raw fish, raw-marinated fish, raw molluscan shellfish, or steak tartare; or a partially cooked food such as lightly cooked fish, soft cooked eggs, or rare meat other than whole-muscle, intact beef steaks as specified in ¶ (C) of this section, may be served or offered for sale upon consumer request or selection in a ready-to-eat form if:

The facility has now purchased pasteurized eggs and has developed a new procedure to allow for the serving of pasteurized over-easy eggs or soft poached eggs.

The Director of Food Services/Executive Chef and the Dietician will monitor adherence to the procedure on an ongoing basis.

5/11/2011



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STATE SURVEY REPORT

Page 3 of 3

NAME OF FACILITY: Stonegates

DATE SURVEY COMPLETED: May 11, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	(1) As specified under ¶¶ 3-801.11(C)(1) and (2), the food establishment serves a population that is not a highly susceptible population;	
	3-8 Special requirements for highly susceptible populations.	
	3-801.11 Pasteurized Foods, Prohibited Re-Service, and Prohibited Food.	
	In a food establishment that serves a highly susceptible population:	
	(C) The following foods may not be served in a ready-to-eat form: P	
	(2) A partially cooked animal food such as lightly cooked fish, rare meat, soft-cooked eggs that are made from raw eggs.	
	Cross refer to the CMS 2567-L survey report date completed 5/11/11, F371.	
·		